Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

UNIVERSITY MEDICAL CENTER
P O BOX 5980
LUBBOCK TEXAS 79408

Respondent Name
SECURITY INSURANCE CO OF HARTFORD

Carrier's Austin Representative Box
#11

MFDR Tracking Number
M4-11-0218-01

MFDR Date Received
SEPTEMBER 13, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are disputing the zero payment received from the insurance carrier. We believe the patient's stay was emergent and should be paid."

Amount in Dispute: $13,549.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent signed for the Notice of Medical Dispute on September 21, 2010. The respondent did not submit a response for review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 20, 2010 through April 28, 2010	Inpatient Hospital Surgical Services	$13,549.78	$10,304.26

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.2 sets out the criteria for medical emergency health care.
3. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 17, 2010
   - 40 – Not Emergency/Urgent care

Explanation of benefits dated July 23, 2010
- 40 – Not Emergency/Urgent care

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Is the insurance carrier's denial "Not Emergency/Urgent care" supported?
3. Which reimbursement calculation applies to the services in dispute?
4. What is the maximum allowable reimbursement for the services in dispute?
5. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

   No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).
2. The insurance carrier denied disputed service with reason code 40 – "Not Emergency/Urgent care." This is not, by itself, a reason to deny reimbursement. Health care is not required to be emergent in order to receive reimbursement. No other denial reasons were presented to the requestor prior to the date the request for MDR was filed with the Division, and therefore, per 28 Texas Administrative Code §133.307(d)(2)(B) any new denial reasons or defenses raised shall not be considered in this review. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
3. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

   No documentation was found to support that the facility requested separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g); for that reason the MAR is calculated according to §134.404(f)(1)(A).
4. §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Documentation found supports that the DRG assigned to the services in dispute is DRG 074, and that the services were provided at University Medical Center. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $7,205.78. This amount multiplied by 143% results in a MAR of $10,3104.26.
5. The division concludes that the total allowable reimbursement for the services in dispute is $10,304.26. The respondent issued payment in the amount of $0.00. Based upon the documentation submitted, additional reimbursement in the amount of $10,304.26 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $10,304.26 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		March 6, 2013
Signature	Medical Fee Dispute Resolution Officer	Date
		March 6, 2013
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.